

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



Centre name:	A designated centre for people with disabilities operated by Camphill Communities of Ireland
Centre ID:	OSV-0003625
Centre county:	Kilkenny
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Camphill Communities of Ireland
Provider Nominee:	Adrienne Smith
Lead inspector:	Noelene Dowling
Support inspector(s):	Paul Pearson
Type of inspection	Announced
Number of residents on the date of inspection:	16
Number of vacancies on the date of inspection:	1

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
19 April 2016 09:30	19 April 2016 20:00
20 April 2016 08:30	20 April 2016 17:00

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

The purpose of this inspection was to inform the decision of the Health Information and Quality Authority (HIQA) in relation to the application by the provider to have the centre registered. All documentation required for the registration process was provided.

This was the second inspection of this centre. A monitoring event had taken place in 2014. In March 2016 HIQA undertook a review of safeguarding practices in a number of the provider's centres including this centre. As a result of the findings the provider was requested to attend a meeting with HIQA in April 2016. A warning letter was

issued and an action plan to improve safeguarding systems was requested at the time. This was duly forwarded by the provider.

This inspection took place over two days. The inspection was also informed by information received by HIQA in relation to fees being charged, contracts and consultation with relatives. While no issues were identified in relation to the management of residents' monies, consultation with and oversight of financial management required improvement.

Inspectors reviewed a number of questionnaires completed by residents or their representatives and spoke with a number of residents and relatives. The responses were positive regarding the quality of their lives, their feeling of safety, how they had meaningful activities and how they were very much involved in making their own decisions. However, there was also commentary indicating that consultation processes with relatives could be improved. The findings of the inspection indicate that this is an area for improvement.

Inspectors also reviewed documentation including policies and procedures, personnel files, health and safety documentation, resident's records and personal plans. Inspectors spoke with residents who could communicate, two relatives, staff, house coordinators and the person in charge.

According to the statement of purpose the service is designed to provide long term residential services to people with moderate to severe intellectual disability, people on the autism spectrum, physical disabilities and challenging behaviours.

The centre is located in a rural area on its own grounds. Transport is required to access the local town and amenities.

Following the inspection the provider was requested to undertake immediate training for some staff in fire safety and in the management of choking incidents and provide evidence to HIQA that this had been undertaken by the 27 April 2016. While the training in fire safety was confirmed the action for training in the management of choking incidents was not adhered to by the provider.

The overall findings indicate good practice in access to healthcare, complaint management, and meaningful activities and recreation for residents.

Some improvements were identified in the following areas

- lack of effective governance and oversight of the care provided:
- potential risk for residents were identified due to poor risk management procedures (Outcome 7)
- poor safeguarding measures in the use of restrictive practices and medication management systems which could expose residents to risks (outcome 8 and 12)
- poor staff training and in some instances skill mix which could pose a risk to residents care were identified (outcome 17)

These issues are covered in more detail in the body of the report and action plan at the end of the report.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation

Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Inspectors found that there was commitment to promoting and supporting residents' capacity to exercise personal choice and ensure they were involved and consulted in their routines and in their care needs.

The residents who could communicate with the inspectors indicated a significant level of satisfaction with their quality of life at the centre. There was evidence that residents were involved in their personal planning, choosing their own activities, personal goals and attended their annual reviews. Staff were seen to speak with residents warmly and respectfully.

A programme of residents meetings was in place. It was apparent from the records that while some residents could not communicate verbally staff acted as their representatives at these meetings. Routines, activities and meal choices were elicited and the preferences acted upon. Residents were encouraged and supported to remain in control of their own finances where this was deemed appropriate and to have information on their healthcare needs. They could attend religious services in the local community.

There was sufficient transport available and staff were consistently available to accompany residents. Staff were observed being sensitive to residents need for privacy and personal belongings were documented. However, this outcome is impacted upon by the language and phrases used in some records and posters which were on public view. This was discussed at the feedback meeting and it was agreed that the terminology would be altered.

There was a written operational policy and procedure for the making and management of complaints which was in line with the regulation. The policy included an external appeals process, overview by the provider and encouraged local and immediate resolution where this was feasible. There were time scales and responsibilities outlined. A pictorial synopsis was posted in a suitable area of the units and some residents told inspectors that they knew who to go to and would do so if they had a complaint. The records seen indicated that a satisfactory outcome and timely reporting occurred. Where it was deemed necessary or serious, managers had undertaken a satisfactory full investigation of a complaint

Judgment:
Compliant

Outcome 02: Communication

Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
It was apparent that staff were very familiar with each resident's non verbal communication.

However, residents' personal plans in all cases did not detail the communication needs and guidelines for staff in relation to these. A number of residents were familiar with the use of sign language but staff did not have training in its use in order to communicate effectively. This is actioned under outcome 17 workforce. A small number of residents also used assistive technology and all had access to media and were assisted with the use of phones.

Judgment:
Non Compliant - Moderate

Outcome 03: Family and personal relationships and links with the community

Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Inspectors were satisfied that familial relationships were maintained and supported via regular visits home and to the centre and via letters and phone calls. Staff spoken with placed an emphasis on this and clearly understood its importance to the residents. There was evidence that residents had opportunities to meet and engage with people from other centres connected with the organisation, external groups and the local community.

Judgment:

Compliant

Outcome 04: Admissions and Contract for the Provision of Services

Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

While the admission process in terms of pre-admission assessment and sourcing of comprehensive information was satisfactory the decision making process was not robust. This is evidenced by two recent admissions one of which had to be discharged within a number of weeks and one which required services, multidisciplinary supports and staffing levels to a degree not currently available to the provider.

None the less, it is acknowledged that a significant level of support had been sourced as the complex needs of the residents became apparent. There were opportunities for phased transitions with the resident and family visiting the centre a number of times with opportunities to speak to co-workers/staff prior to admission.

Inspectors found that the transfer of information available should a resident require an admission to acute care was satisfactory.

The action from the previous inspection, in relation to the provision of a suitable contract for the provision of services, had been partially resolved. There was an easy read contract available which residents signed. However, the formal contract, detailing the precise costs was not in all cases signed on behalf of the resident where this was

required due to the resident's dependency level. Residents' representatives were not provided with detailed suitable contract to sign on behalf of the resident where this was necessary.

Judgment:

Non Compliant - Moderate

Outcome 05: Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

Documentary actions in relation to this outcome identified at the previous inspection had been addressed. From a review of eight residents' records there was evidence that all residents had detailed personal care plans which were reviewed internally and a formal annual review was also held. The centre has recently commenced using a revised system for documenting personal plan, supports and reviews. When completed this system will be satisfactory and they are in format which is available to the residents.

There were a range of pertinent assessments undertaken by clinicians including speech and language, physiotherapy, occupational therapy, psychosocial and mental health needs of residents. The personal plans developed were inclusive of the assessments undertaken.

While some of the annual reviews showed evidence that these assessed needs and the outcome of any interventions were considered this was not a consistent finding. Some significant issues including restrictive practices and mental health needs were not reviewed at the meetings.

There was also an absence of support plans for a number of identified needs including skin care and integrity, dietary needs and self harm and no comprehensive health care screening at defined planned intervals which would have guided care practice more effectively. From information received it was apparent in some instances that family members were not consistently consulted but in some instances were informed of issues at a later date. For example, this included a medical appointment.

Personal goals in some instances did not detail how they would be achieved and in others no goals were identified. For example, goals in relation to basic reading and money management had not been actioned.

Within the easy read personal plans there were personal details of residents' likes and dislikes activities/work and hobbies, and personal care using photographs as well as narrative. The residents had access to these themselves and one resident told inspectors about this. Daily diaries were maintained by staff which were seen to contain pertinent information on residents' activities, health, behaviour and general well-being.

The residents had access to a range of meaningful activities of their choosing. These included participating in the farm work, gardens, caring for the animals and crafts. They also took part in horse riding, local art groups, and attended swimming and leisure clubs or the cinema in local towns. There was staff support identified for residents to ensure their activities took place and that they were supported in their work.

They also participated in the daily life of the houses, for example they helped with laundry, cooking and undertook general housekeeping chores to promote their independence and a sense of active participation in the life of the centre. The site provides a tranquil and safe setting and they had considerable freedom of movement between the units.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

Actions required following the previous inspection had been addressed. The premises was well maintained and suitable for purpose.

The centre comprised of six houses/apartments and ancillary buildings located amongst a number of private houses in a rural location. The first house was a large family farm-house style two-storey house which accommodated four residents and four co-workers, the second premises was a small two storey house which had a recently added single

storey extension and accommodated one resident and three co-workers.

The third premises was a large two-storey house which accommodated four residents and five co-workers. The fourth house was a large two-storey house which accommodated four residents and four co-workers. The fifth house was two storey house which accommodated one resident and three co-workers. The last house in the centre was a first floor apartment which accommodated one resident and two co-workers.

All premises were easily accessible, bright, well ventilated, had central heating and were decorated to an adequate standard. The premises were homely and met the needs of residents with suitable furniture, comfortable seating and residents' art work. on display .One bedroom had been extended to provide additional space for one resident who needed specialised equipment.

There were adequate showers and toilets with assistive structures in place including specialised beds, ceiling hoists, hand and grab rails; to meet the needs and abilities of the residents. There were suitable sitting, recreational and dining space separate to the residents' private accommodation and separate communal areas. Residents that showed inspectors their rooms stated that they were happy with the living arrangements and all had personalised their space with photographs of family and friends and personal memorabilia. There were options for residents to spend time alone if they wished with a number of communal sitting rooms available.

Equipment for use by residents including wheelchairs, mobile and static hoists and assisted chairs had up to date servicing of equipment records. There were suitable accessible grounds/outside areas and a variety of suitable pathways for residents use. There was a therapy building that contained a hydro-bath, a communal meeting house and a selection of farm type buildings that housed farm animals. There were a number of suitable garden areas with seating/tables provided for residents use located at a number of locations within the grounds of the centre.

Judgment:
Compliant

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

Actions required following the previous inspection in relation to the content of the risk management policy had been addressed. Inspectors found that there were procedures in place for the identification of risks guided by the organisational policy on risk management, and a local risk register was also found to be in place. The inspector found clinical, behavioural and environmental risks were identified and documented in the centre.

However, inspectors noted that some risk areas were not consistently identified assessed and did not have adequate control measures in place as an ongoing process.

These included:

- no patient handling plans for residents who required the use of hoists
- no plan for a resident at risk of wandering or significant self harm

A further failing included nine staff who did not have fire safety training and training in the managing of choking incidents for all staff was required. The person in charge was requested to remedy this by 27 April 2016 and provide evidence to HIQA that this had been done. According to the documents provided the fire training was confirmed as having taken place by the due date but the training in the management of choking incidents was deferred for one week.

In addition other actions in relation to fire safety were identified:

- there was no emergency lighting in one apartment
- two fire doors did not close sufficiently to contain a fire
- lack of training or drills for staff in the use of a specific evacuation procedure for one very dependant resident.

Records seen by inspectors indicated that five medicine errors had occurred since January 2015. These were primarily related to human error either with keys or failure to administer. While systems were put in place following individual incidents there was no overview analysis to support systems and learning in the future.

Some audits had been undertaken including medicines management, restrictive practices and accidents and incidents. The latter was very detailed. However, the restrictive practice and medicines management audits did not demonstrate sufficient review, analyses or actions to ensure learning.

There were fire evacuation notices and fire plans publicly displayed in each premises. Fire marshals were assigned to each unit to monitor exits and the fire alarm. Fire safety was included in the induction for new co-workers.

Maintenance records for servicing of fire equipment including the fire alarm system, emergency lighting and fire extinguishers and fire blankets were available. An emergency plan was in place and this included arrangements in the event the centre had to be evacuated. Emergency phone numbers were also easily accessible to staff.

There were individual risk assessments compiled for residents which included the risk of falls, or epileptic seizures. Some effective strategies were used including the use of non

slip mats and there were guidelines in the event of seizures in the bath or elsewhere. Additional supervision was indicated for a number of residents and this was implemented.

The policy on the prevention and control of infection was satisfactory. There was suitable laundry equipment in each house and the houses were very clean.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The action required from the previous inspection in relation to the use of restrictive practices and documentation of such had been partially addressed. The inspector was satisfied that residents' safety and welfare was prioritised in principal. However, improvements were required in the management of residents' finances and significant improvements were required in the use of restrictive procedures.

All residents had their own bank accounts. In most instances they required considerable staff support to manage their monies and transactions. Records of transactions and debits were maintained and receipts were audited against these records. However, there was no policy which provided guidance for the house co-coordinators as to limits on withdrawals or items to be purchased from the accounts. These decisions were left to the discretion of the house co-ordinator. This was especially pertinent to a number of residents for whom the provider was acting as de-facto guardian in the absence of other persons. There was also a lack of clarity as to who was authorised to give permission for treatment and spending for a resident who was a ward of court.

While inspectors found no evidence of any irregular financial activity this lack of oversight and decision making did not support safe practice and ensure that residents were protected from the risk of financial abuse.

The management and oversight of restrictive practice also required review. There was a detailed policy which was in accordance with national guidelines but this was not adhered to. There was evidence of inconsistent risk assessment, lack of oversight and satisfactory rationale for the use of systems as they were implemented.

A number of practices were used which included lap belts, bedrails, locked doors, stair gates and audio monitoring systems. Some risk assessments for the use of lap belts on chairs or bedrails had evidence of multidisciplinary oversight and safety management plans were also evident.

This was not the case in all instances however. A number of internal doors were locked or stair-gates were used to prevent access or exit. Some assessments did not demonstrate what, if any, alternatives had been tried or if the system being implemented was the most effective and safe mechanism to mitigate the risk identified. For example, an audio monitor was used to alert sleeping staff in the event of a resident having a seizure. It was not demonstrated that this was the most effective or evidence based system to manage such a risk.

In addition, inspectors saw a purpose built, (contained on all sides) system used to provide sleeping accommodation for one resident. When closed it required the removal of two bolts to gain access to, or visual sight of the resident due to its height. There had been concerns raised previously in regard to this item but this was not addressed by the provider.

There were potential risks identified to justify the use of this system. However, there was no evidence that this system had been adequately reviewed in a number of years or that any serious efforts had been made to reassess the risks and find a more suitable alternative for the resident. The risk of using this system had not in itself been assessed, nor had the impact on the resident of sleeping in this. In this case a waking night staff was available who inspectors were told checked on the resident hourly. However, there was no system for alerting these staff to the actual risk identified which was seizure activity.

The policy on the management of behaviour was not in accordance with national guidelines and did not guide practice. There were behaviour support plans in a place for some but not all residents who required this. Psychiatric review of residents had taken place and a behaviour support specialist was assisting staff in the development of support plans. Triggers and non verbal expressions were clearly understood by staff. Staff had received training in the support of behaviours that challenge.

Diversionary strategies were employed. Inspectors found that staff were aware that detailing and adhering to residents preferences for the minutia of their daily live was used to good effect to reduce anxiety and therefore prevent behavioural incidents. Medication was used on a p.r.n. (administered when required) basis to manage behaviours that challenge. While inspectors did not find this was overused there was no protocol to guide its use and ensure it was used only as directed.

Following a review undertaken by HIQA in 2016 the provider was requested to implement a safeguarding action plan and submit this to HIQA. One issue of concern identified was the ability of staff in the centre to identify potential signs of abuse and report and respond accordingly. From a review of the documentation and from speaking with staff and house coordinators inspectors were satisfied that systems for recognising, responding to and reporting indications of potential abuse had been implemented. Systems to ensure that staff recorded and reported any changes in mood, behaviour or unexplained bruising which would indicate concern were in place. The policy on this had not been devised but this was rectified during the inspection.

The safeguarding plan submitted by the provider included timeframes for actions. The initial actions identified which were the sharing of information and learning processes between centres had commenced.

There were safeguarding plans available and where necessary the gender of the carers to provide personal care to residents was specified.

The policy on safeguarding was in accordance with the national requirements and training had taken place for staff. Three staff, including the designated officer had undergone the training in the revised procedures. The designated officer was found to be well informed and clear on her role and responsibilities.

There were a number of children living on the campus. The Children First procedures were available.

Residents who could communicate informed inspectors that they felt very safe and well cared for in the centre and families also stated that they felt their relatives were safe. A house coordinator had sought advocacy and social work support for a particularly vulnerable resident.

Judgment:
Non Compliant - Major

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The inspector found that the person in charge had not complied with the responsibility to forward the required notifications to HIQA. Notifications not forwarded included a

significant number of restrictive practices and the use of chemical restraints.

Judgment:

Non Compliant - Moderate

Outcome 10. General Welfare and Development

Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Residents' opportunities for new experiences, social participation, training and employment were facilitated and supported.

Inspectors observed that residents received practical training in horticulture, food preparation, agriculture and animal care. The crops harvested were used in the food preparation and residents were very proud of their achievements.

Residents enjoyed participating in sports such as swimming and soccer in local leisure centres if they so wished. Residents participated in range of varied interests within the centre during the day such as horse riding, art, crafts, woodwork, cooking and horticulture.

Inspectors found that a formal assessment of residents' education, training and development needs was lacking. This assessment would ensure that goals relating to education, training and development were developed in accordance with each resident's ability, talents and preferences. However, inspectors were satisfied that the staff were very aware of the residents' capacity and interests despite this.

Judgment:

Compliant

Outcome 11. Healthcare Needs

Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The actions required from the previous inspection in relation to staff training in dysphasia had taken place and further training was planned. Residents' overall healthcare needs, including nutritional needs, were met and residents had access to appropriate medical and allied healthcare services.

Inspectors reviewed a sample of residents' files and there was evidence of timely and frequent access to their GP of choice. In line with their needs, residents had ongoing access to allied healthcare professionals including speech and language therapists, dentists and chiropodists. Records of referrals and reports were maintained in residents' files.

There was evidence that where treatment was recommended and agreed by residents, this treatment was facilitated. Residents' right to refuse medical treatment was respected.

A document which outlined personal details, contact details for next of kin and the centre, medical history, GP, current medication and allergies was available to ensure the exchange of comprehensive information on admission to hospital.

Inspectors saw that residents received support at times of illness and a policy was in place to guide staff in meeting residents' physical, emotional, social and spiritual needs.

The inspector observed that residents were encouraged and enabled to make healthy living choices in relation to exercise, vaccination and healthy eating. Where residents were assessed as requiring modified or altered diets the directions were available and seen to be adhered to by staff.

Inspectors observed that there were ample quantities of food and drink; which was properly and safely prepared, cooked and served. Many of the fruits and vegetables used to prepare meals had been grown by residents on the farm. Residents who could do so participated in the preparing and cooking of the meals. The meals were social occasions shared by residents and staff.

Judgment:

Compliant

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The documentary issues identified at the previous inspection had been addressed. However, practices required some improvement. There was a centre-specific medication policy that detailed the procedures for safe ordering, prescribing, storing administration and disposal of medicines.

Inspectors reviewed a sample of medication prescription and administration records and had concerns about transcribing practices. The medication being administered in one instance did not correlate with the prescribed dosage. The house coordinator acted promptly to address the discrepancy on the day. The dosage being administered was in fact correct and there was no ill effect to the resident. However, the risk of errors were further compounded by the fact that non nursing staff were transcribing the medications from the prescription records onto a separate administration sheet with no suitable processes in place to manage this. In effect, there were three documents citing different ultimate dosages for this particular medication. Inspectors acknowledged that the transcribing practices were undertaken in order to support the volunteers who regularly administered medication. However, it placed residents at risk.

In addition, staff had been administering night time sedative medication early in the evening for one resident. While this was rectified by the coordinator as soon as it was discovered it was not clear how this had occurred as the medication was supplied in blister packs. In view of these findings the dispensing pharmacist agreed to provide suitable alternative medication management documentation to the staff on the day of the inspection.

It is acknowledged that the house coordinator was conscious of the potential for errors and had clearly identified discrepancies as they occurred. A number of other medication errors were recorded, in one instance due to staff not understanding the instruction to administer the medication. These issues are actioned outcome 7 health and safety and under outcome 17 Workforce.

Only 20 staff had training in medicines management. Medicines for residents were supplied by a local community pharmacy. However, these findings do not demonstrate that the person in charge adhered to the requirement to facilitate the pharmacist in meeting the obligations to the residents.

Residents' medication was stored and secured in a locked cupboard in each premises with a key holding procedure. Inspectors saw and staff/co-workers confirmed that medicines requiring refrigeration or additional controls were not in use at the time of inspection.

There was evidence that residents were offered the opportunity to take responsibility for their own medicines following an objective assessment.

Staff outlined the manner in which medications which are out of date or dispensed to a resident but are no longer needed are stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal.

Judgment:

Non Compliant - Moderate

Outcome 13: Statement of Purpose

There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The statement of purpose had been forwarded to HIQA as part of the application for registration and contained all of the required information. Admissions to the centre and care practices as seen were congruent with the statement of purpose as currently outlined.

Judgment:

Compliant

Outcome 14: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Inspectors were satisfied that some governance structures were satisfactory but evidence of adequate oversight and effective management was not fully demonstrated. This is apparent by the findings in relation to risk management, restrictive practices and medicines management.

The designated centre was managed by a suitably qualified person who had relevant experience. She was full-time in post and was fully involved in the day to day operations of the centre and the organization. Responsibilities were clearly defined and the nominee of the provider and the person in charge demonstrated an awareness of the responsibilities of the role. Resources were well utilised. Each house was managed by a coordinator who was trained in social care and responsible for the day to day delivery and oversight of care. The issue of staffing when these employed qualified personnel were not present is detailed in outcome 17 Workforce.

The organization has a number of mechanisms to support the overall governance. These include local committee governance groups, national health and safety systems and formal reporting structures.

As required by the regulations the provider nominee had undertaken an unannounced visit to the centre in 2015 and again in 2016. A detailed report of the findings was compiled and an action plan for completion was also implemented. Issues identified included the updating of some residents' needs assessment and the risk register. A residents' survey had been undertaken in November 2015. Issues identified as necessary included easy read menu books which were provided. The annual report was forwarded to HIQA.

The inspector was informed that a relative's survey was being undertaken. A formal system for compiling information on accidents and incidents had been commenced in order to ensure that information was available.

There were other avenues including the residents meetings and day-to-day consultation to ensure resident's views were heard. Inspectors were satisfied that the systems provided sufficient information to inform the annual report.

Judgment:

Non Compliant - Moderate

Outcome 15: Absence of the person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The provider was aware of the requirement to notify HIQA of any absences of the person in charge and inspectors were informed that no such absences had occurred. A suitably qualified and experienced house coordinator was nominated to this position and the documentation was in the process of being forwarded. The arrangement as outlined was satisfactory. The person demonstrated knowledge and competency during the inspection.

Judgment:

Compliant

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The provider had satisfactory resources to provide care and support for residents. Staffing was in the process of being increased at the time of the inspection.

Judgment:

Compliant

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:

Responsive Workforce

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The workforce in the centre was a combination of short term volunteers, coordinators/ long term volunteers and paid members of staff in accordance with its function and model of care. The provider had increased the number of paid staff available and provided one to one supports for some residents as a response to changing and increasing needs. This included waking night staff in one unit and one to one supports for some other residents.

The senior staff were primarily present in the day time which leaves a significant responsibility on the new short term volunteers to provide care and oversee resident safety after this. The person in charge informed inspectors that they were aware of this vulnerability and were in the process of employing fulltime staff to support the current arrangements. A long term senior volunteer is always available on the campus at night. The current skill mix is not suitable.

The inspectors found that there were deficits in training available to staff including patient handling ,first aid (including emergency procedures for choking) and medicines management training. While it may not be necessary for all staff/volunteers to have all of this training there was no evidence that the allocation of staff as per the rosters took account of these deficits.

While there were planned and current rosters available it was not always apparent which of the volunteers who live in the houses was actually responsible for responding to residents at night. These are historical practices but may present a risk to the safety of residents.

Communication and monitoring systems between staff and management were evident. Management and staff meetings took place regularly and the records seen indicate that resident care was the priority for the agenda. A system of co-worker meetings was also implemented.

The supervision systems for staff were not consistently applied. House coordinators had an annual appraisal and the records seen showed that this focused on resident care and staff development to support this. However, the supervision for other staff and volunteers was not consistently applied.

Co-workers were recruited from a number of overseas agency's who specialise in training and support of volunteers. There was a detailed process for recruitment of these volunteers. Senior staff were allocated responsibility for ensuring that new staff /co-workers were supervised and familiar with the needs of the residents. New staff were briefed in fire safety procedures and there was a detailed induction programme which included supernumery time for staff. Volunteers confirmed this.

From a review of a sample of personnel files inspectors noted good practice in recruitment and the documents required under schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres For Persons (Children and Adults) with Disabilities) Regulations 2013 were available. It is practice that all overseas co-workers/ volunteers have a police clearance from their country of origin.

Staff were observed to be patient, engaged with and very supportive of the residents and were aware of the statutory requirements and standards in relation to the delivery of care and copies of relevant guidance was available at the centre.

Judgment:
Non Compliant - Moderate

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Records of personal belongings were maintained and records required in relation to staff and residents were found to be complete.

A number of policies required amendment. These included the management of residents' finances and the behaviour support policy.

Documents such as the residents guide and directory of residents were available and up to date. The inspector saw that insurance was current. Reports of other statutory bodies were also available. A visitors log was available.

Judgment:
Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Noelene Dowling
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Camphill Communities of Ireland
Centre ID:	OSV-0003625
Date of Inspection:	19 April 2016
Date of response:	20 May 2016

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 02: Communication

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Residents' personal plans in all cases did not detail the communication needs and guidelines for staff to support them.

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

1. Action Required:

Under Regulation 10 (2) you are required to: Make staff aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.

Please state the actions you have taken or are planning to take:

The communication section of the Personal Plans will be reviewed within the next three months – by 31/08/2016. A Speech and Language Therapist will be engaged to support this process. Two of our employed staff are due to be trained in the use of Lamh on the following dates:

Module 1 = 1st July 2016

QQI Level 5 (4 day course) – 29th, 30th September, 27th, 28th October 2016

Proposed Timescale: 31/08/2016

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The capacity of the service to provide care for all residents was not considered during recent admission decisions.

2. Action Required:

Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:

We have appointed a senior member of staff who will take responsibility for any future potential admissions. We have also appointed an Admissions Committee. The admissions process will be multidisciplinary in line with good practice.

Proposed Timescale: 27/05/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Residents representatives were not provided with detailed suitable contract to sign on behalf of the resident where this was necessary.

3. Action Required:

Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:

Currently all our residents have contracts in accessible format, all sixteen are signed by the residents, fourteen are also signed by their family or representatives.

All contracts will be reviewed and all family members or representatives will be issued with detailed suitable contracts in addition to the existing accessible contracts.

Proposed Timescale: 31/08/2016

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some personal plans did not take account of the residents assessed needs or presenting needs.

4. Action Required:

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

Please state the actions you have taken or are planning to take:

Personal Plans will be audited and reviewed. The Personal Plans that did not take account of the residents' assessed needs or presenting needs will be revised to reflect the assessed needs of the resident in question. This process will be done in consultation with the Behavioural Support Specialist.

Proposed Timescale: 31/08/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Personal plan reviews were not informed by multidisciplinary involvement.

5. Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

Please state the actions you have taken or are planning to take:

All Personal Plan reviews will be brought in line with Action 5 by 31/08/2016

Proposed Timescale: 31/08/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Personal plans and reviews did not consistently involve the representatives of the resident where this was necessary.

6. Action Required:

Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

Please state the actions you have taken or are planning to take:

All Personal Plan reviews will be brought in line with Action 6 by 31/08/2016

Proposed Timescale: 31/08/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There was no cohesive system for the assessment and management of risk as part of an on-going risk management

Risk identified were:

- risks of resident wandering
- risks of residents choking
- risks of the sue of the hoist

7. Action Required:

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:

- We are in process of recruiting a waking night staff to monitor resident in question. This will bring our night time staff complement up to three.
- All frontline staff are now trained in dealing with episodes of choking. This was carried out on 09/05/2016 by an external registered trainer.
- Disphagia Awareness training which was organised by HSE in Kilkenny was undertaken by a number of Kyle staff on 21/01/2016. A further training day on Disphagia Awareness by the HSE in Kilkenny was undertaken on 25/05/2016 by a further two members of staff.
- In addition, comprehensive First Aid training took place on 11/05/2016.
- Training for staff using hoist will be completed by 31/05/2016

NOTE: We have bought a defibrillator which will be situated in the reception area of the main office. This will be installed by 31/05/2016. Kyle has currently five FETAC 5 Occupational First Aiders who are trained in the use of the defibrillator.

Proposed Timescale: 31/05/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Nine staff did not have training in fire safety and management.

8. Action Required:

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:

- All frontline staff have now received training in fire prevention, emergency procedures, fire fighting equipment, fire control techniques and arrangements for the evacuation of residents. Fire Safety training was carried out on 25/04/2016
- Sessions on each individual building layout and escapes routes and location of fire alarm call points and arrangements for the evacuation of the residents living in the individual houses will be undertaken by Health & Safety Officer and will be completed by 31/05/2016.

Proposed Timescale: 31/05/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Fire drills did not take account of the specific evacuation procedures necessary for one resident.

9. Action Required:

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:

- In fire training sessions, which take place two/three times a year, the external trainer takes into account and demonstrates how to evacuate this particular resident
- A full training was held on 25/04/2016 with particular emphasis on the use of the evacuation sheet.
- Furthermore our internal H&S Officer undertook a fire drill on 18/05/2016 in order to emphasise the importance of safe evacuation for one particular resident (a staff

member engaged in the process and was actually evacuated on the sheet in keeping with the external training)

- All future fire drills within the house will take account of the specific evacuation necessary for this individual resident and will follow the correct procedure and recorded as such.

Proposed Timescale: 27/05/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There was no emergency lighting in one unit.

10. Action Required:

Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

Please state the actions you have taken or are planning to take:

On 28/04/2016 and 29/04/2016, work was undertaken in this unit and emergency lighting was installed. We are satisfied that the resident has adequate means of escape from the building. Her key worker will ensure that resident understands her means of escape with regular recorded fire drills.

Proposed Timescale: 29/04/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Some fire doors were not satisfactory to contain a fire.

11. Action Required:

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:

All fire doors have been checked and we have identified the fire doors that require remedial attention. Arrangements have been made to make good.

Proposed Timescale: 03/06/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

A number of restrictive procedures were used which were not implemented in accordance with national guidelines and best practice:

- the rationale for the use of some restrictive practices was not clearly developed
- the procedures were not risk assessed
- alternative had not been tried or sourced
- the procedures were not adequately reviewed for suitability or effectiveness
- they were not assessed as being the least restrictive or for the shortest duration.

Appropriate protocols were not in place to guide the consistent use of PRN medication used in response to behaviours that challenge.

12. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:

- As part of the Personal Plan review, the rationale for the use of restrictive practice will be clearly outlined.
- All restrictive procedures will be risk assessed.
- During the risk assessments, any possible alternatives will be discussed with the resident's safety being taken as priority.
- All restrictive practices will be reviewed and amended if deemed safe to do so. This will include review of the audio monitor and locked doors. The review will take account of the suitability, the effectiveness and the safety of the said procedures for the residents. Should we identify a less restrictive practice that will ensure the residents' safety and welfare, it will be implemented with immediate effect particularly if it can be used for a shorter duration.
- PRN Medication (relating to one resident) - A multidisciplinary review has been scheduled with the particular resident in question for 27/06/2016 to establish appropriate protocols for the use of PRN medication. The PRN medication is currently prescribed by a consultant psychiatrist.
- The stair gate in one unit has been assessed and was removed on 27/05/2016.
- The stair gate in the other unit has been assessed and was removed on 24/05/2016.
- Resident in question is currently away. He has been there since 23/04/2016 and will be there for the foreseeable future. A meeting has been set for Monday 30/05/2016 to review the resident's current situation and an alternative bed replacement is one of the priorities on the agenda.

Proposed Timescale: 31/08/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Oversight of the management of residents finances and legal arrangements were not robust.

13. Action Required:

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:

Money Management has been reviewed and brought in line with Camphill Communities of Ireland policy. There has been a limit set of €200 weekly which may be withdrawn from a resident's account. Larger withdrawals over this amount will need prior approval and authorisation of the Person in Charge.

Proposed Timescale: 26/04/2016

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Notifications of the use of a number of restrictive practices were not forwarded to HIQA as required.

14. Action Required:

Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

Please state the actions you have taken or are planning to take:

In the notification for 1st Quarter of 2016, all physical and environmental restraints were reported. However we accept that we did not include chemical restraint in the case of one resident.

- This omission on chemical restraint was rectified on 20/05/2016 – unfortunately we sent a blank form in error – this error was further rectified on 27/05/2016. All chemical restraints will be included in all future quarterly returns.
- Door locks were notified for the first time on the new style Qtrly. Form on 13/04/2016.
- The alarm monitor was notified for the first time on the new style Qtrly. Form on 18/04/2016
- The stairgates were notified for the first time on the new style Qtrly Form on 24/05/2016

All forms of restraint if in use in the centre will be notified in the quarterly notifications in future.

Proposed Timescale: 31/07/2016

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Systems for the administration of medication did not protect residents. Transcribing practices were not safe. There was insufficient oversight and monitoring of medication practices.

15. Action Required:

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:

- System has been changed – one house is using a pharmacy generated MAR chart which will be replicated in all houses by 30/06/2016.
- We have engaged a general registered nurse who will take over the administration of medications particularly in the mornings. The nurse will put a system in place that the staff will adhere to for evening administration.
- Please note that, at present, we have just one resident on midday medication – house staff will ensure that this medication is administered safely and at the correct time and recorded.
- All frontline staff have been trained in medication training. The last Medication training took place on 10/05/2016.
- Two senior members of staff are booked to attend an HSE-run Incident Management Training Day on 15/06/2016.

Proposed Timescale: 30/06/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Management systems did not ensure that the care provided was safe suitable and monitored.

16. Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:

The Annual report by Provider Nominee has been addressed in the Factual accuracy Form which was returned to HIQA on 18/05/2016 and an additional copy was included in the attachment. All other issues of noncompliance referred to in this section such as risk management, restrictive practices and medication management have been addressed in the appropriate section of this Action Plan.

Proposed Timescale: 18/05/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There was a reliance on volunteers to provide care and support in the absence of oversight by suitably experienced trained staff.

17. Action Required:

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:

- All frontline staff have now completed patient handling training
- All frontline staff have now completed First Aid training which included emergency procedures
- All frontline staff have also been trained in emergency procedures for choking which was in addition to their First Aid training.
- All frontline staff have now completed medication training.
- We are now in the process of developing rosters that will reflect the allocated volunteer who has responsibility for each resident. These rosters will have a particular emphasis for night time cover and in all cases will be backed up by a suitably qualified and experienced night worker.

Proposed Timescale: 31/05/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Training for staff in areas pertinent to the residents needs was not provided. This included crucial training in managing episodes of choking, medication management, communicating with residents and transporting of residents.

18. Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:

- All frontline staff have now completed patient handling training
- All frontline staff have now completed First Aid training which included emergency procedures
- All frontline staff have also been trained in emergency procedures for choking which was in addition to their First Aid training.
- All frontline staff have now completed medication training.
- Two of our employed staff will be trained in the use of Lamh - Module 1 on 01/07/2016 and QQI Level 5 (4 day course) is booked for 29 and 30/09/2016, 27 and 28/10/2016.
- Staff who have undertaken courses that require regular refreshers will be offered these refreshers as they fall due.
- CPD of all staff will be monitored during supervision.

Proposed Timescale: 27/05/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

All staff or volunteers were not appropriately supervised.

19. Action Required:

Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:

Supervision in accordance with CCoI policy has commenced and will be monitored on a regular basis

Proposed Timescale: 27/05/2016

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Adequate policies on the management of residents' finances and the use of restrictive practices required to be devised and implemented.

20. Action Required:

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:

- A revised CCoI policy on the Management of Residents' Finances was implemented on 22/04/2016 and will be reviewed at latest 17/11/2017 or earlier if required. A ceiling of €200 weekly was put in place on 26/04/2016 by Person in Charge in regard to withdrawals from residents' accounts by staff. If larger amounts are required, this must be authorised by Person in Charge.
- All restrictive measures will be reviewed by a multidisciplinary team in line with CCoI policy

Proposed Timescale: 31/08/2016